

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State of Texas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Subject to requirements, limitations and exclusions contained in this State Plan, the state agency or its designee reimburses hospitals approved for participation in the Texas Medical Assistance (Medicaid) Program for covered Title XIX hospital services provided to eligible Medicaid recipients on the following basis:

1. Except for inpatient services provided in in-state children's hospitals, and except as otherwise specified in subsection (q) of this section, covered inpatient hospital services are reimbursed in accordance with the Texas-based Diagnosis Related Group Prospective Payment System methodology.

Reimbursement Methodology for Inpatient Hospital Services

(a) Introduction. Except as otherwise specified in subsection (q) of this section, the Medicaid program reimburses hospitals, except in-state children's hospitals, for covered inpatient hospital services using a prospective payment system. In-state children's hospitals are reimbursed for covered inpatient hospital services using the methodology described in subsection (o) of this section. For hospitals other than in-state children's hospitals, the state agency or its designee groups hospitals into payment divisions using the average base year payment per case in each hospital after adjusting each hospital's base year payment per case by a case mix index, a cost-of-living index, and a budgetary reduction factor of 10%. The budgetary reduction factor for admissions occurring in state fiscal year 1990 (September 1, 1989 - August 31, 1990) is 7% and the budgetary reduction factor for admissions occurring in state fiscal year 1991 (September 1, 1990 - August 31, 1991) is 5.5%. For admissions occurring in state fiscal year 1992 (September 1, 1991 - August 31, 1992) and subsequent state fiscal years, a budgetary reduction factor is not applied. The payment divisions are separated into \$100 increments. If a payment division has less than 10 observations for Medicaid data, the state agency or its designee considers that payment division to be statistically invalid. Hospitals within that payment division are placed into the nearest valid payment division.

(b) Definitions. The following words and terms shall have the following meanings, unless the context clearly indicates otherwise.

(1) Diagnosis-related group (DRG). The taxonomy of diagnoses as defined in the Medicare DRG system or as otherwise specified by the state agency or its designee.

(2) Case mix index. The hospital-specific average relative weight.

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(3) Relative weight. The arithmetic mean of the dollars for a specific DRG divided by the arithmetic mean of the dollars for all cases.

(4) Standard dollar amount. The weighted mean base year payment for all hospitals in a payment division after adjusting each hospital's base year payment per case by a case mix index, a cost-of-living index, and a budgetary reduction factor of 10%. The budgetary reduction factor for admissions occurring in state fiscal year 1990 (September 1, 1989 - August 31, 1990) is 7% and the budgetary reduction factor for admissions occurring in state fiscal year 1991 (September 1, 1990 - August 31, 1991) is 5.5%. For admissions occurring in state fiscal year 1992 (September 1, 1991 - August 31, 1992) and subsequent state fiscal years, a budgetary reduction factor is not applied. The state agency or its designee establishes a minimum standard dollar amount of \$1,600 and applies it to those hospitals whose standard dollar amount is less than the minimum. The state agency or its designee applies cost-of-living indexes to the standard dollar amounts established for the base year to calculate standard dollar amounts for prospective years. A cost-of-living index is not applied to the minimum standard dollar amount.

(5) Base year. A 12-consecutive-month period of claims data selected by the state agency or its designee as the basis for establishing the payment divisions, standard dollar amounts, and relative weights. The state agency or its designee selects a new base year at least every three years.

(6) Base year payment per case. The payment that would have been made to a hospital if the state agency or its designee reimbursed the hospital under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248. In calculating the base year payment per case, the state agency or its designee uses the interim rate established at tentative or final settlement, if applicable, of the most recent cost reporting period up to and including the cost reporting period associated with the base year.

(7) Interim rate. Total reimbursable Title XIX inpatient costs, as specified in paragraph (6) of this subsection, divided by total covered Title XIX inpatient charges per tentative or final cost reporting period. Beginning with 1985 hospital fiscal year cost reporting periods, the interim rate established at tentative settlement includes incentive/penalty payments to the extent that they continue to be permitted by federal law and regulation and continue to be included on Title XVIII cost reports.

(8) New hospital. A facility that has been in operation under present and previous ownership for less than three years and that initially enrolls as a Title XIX provider after the current base year. A new hospital must have been substantially constructed within the five previous years from the effective date of the prospective rate period.

(9) In-state children's hospital. A hospital within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

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(10) Out-of-state children's hospital. A hospital outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(c) Calculating relative weights and standard dollar amounts. The state agency or its designee uses recent Texas claims data to calculate both the relative weights and standard dollar amounts. A relative weight is calculated for each DRG and applied to all payment divisions. A separate standard dollar amount is calculated for each payment division. Except for border hospitals with a Texas Medicaid provider number beginning with an H and out-of-state children's hospitals, the state agency or its designee uses the overall arithmetic mean base year payment per case, including the cost-of-living update as specified in subsection (n) of this section as the standard dollar amount to reimburse out-of-state hospitals. The overall arithmetic mean base year payment per case, including the cost-of-living update as specified in subsection (n) of this section, is also used as the standard dollar amount to reimburse military hospitals providing inpatient emergency services for admissions on or after October 1, 1993. The calculation of the standard dollar amount for out-of-state children's hospitals is described in subsection (r) of this section.

Except for new hospitals, the overall arithmetic mean base year payment per case, including the cost-of-living update as specified in subsection (n) of this section, is also used as the standard dollar amount to reimburse hospitals that initially enroll as a Title XIX provider after the current base year. The standard dollar amount for new hospitals is the lesser of the overall arithmetic mean base year payment per case plus three percentile points, including the cost-of-living update as specified in subsection (n) of this section, or the hospital's average Medicaid cost per Medicaid discharge based on the tentative or final settlement, if applicable, of the hospital's first 12-month cost reporting period occurring after the hospital's enrollment as a Title XIX provider. In the event that the new hospital is a replacement facility for a hospital that is currently enrolled as a Title XIX provider, the hospital is reimbursed by using either the standard dollar amount of the existing provider or the standard dollar amount for new hospitals, whichever is greater. The use of the hospital's average Medicaid cost per Medicaid discharge, after adjusting for case-mix intensity, as its standard dollar amount is applied prospectively to the beginning of the next prospective year and is applicable only if the tentative or final settlement is completed and available at least 60 days before the beginning of the prospective year. The hospital's Medicaid costs are determined using similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248.

When two or more Title XIX participating providers merge, the department or its designee uses the weighted average of the Medicaid inpatient costs, as described in this subsection, of each of the individual providers to calculate a standard dollar amount, effective at the start of the next prospective period, to be used to reimburse the merged entity. Acquisitions and buyouts do not result in a recalculation of the standard dollar amount of the acquired provider unless acquisitions or buyouts result in the purchased or acquired hospital becoming part of another Medicaid participating provider.

When the state agency or its designee determines that the state agency or its designee has made an error that, if corrected, would result in the standard dollar amount of the provider for which the error was made changing to a new payment division, either higher or lower, the state agency or its designee moves the provider into the correct payment division, and the

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department or its designee reprocesses claims paid using the initial, incorrect standard dollar amount that was in effect for the current state fiscal year by using the existing standard dollar amount of the payment division in which the provider was moved. In the determination of the corrected payment division, the department or its designee uses the relative weights that are currently in effect for the state fiscal year. The correction of this error condition only applies to the current state fiscal year payments. No corrections are made to payment rates for services provided in the previous state fiscal years.

If a specific DRG has less than 10 observations for Medicaid data, the state agency or its designee uses the corresponding Medicare relative weight, except for DRGs relating to organ transplants. Relative weights for organ transplant DRGs with five to nine observations will be developed using Medicaid-specific data. Organ transplant DRGs with less than five observations will use Medicare relative weights. The relative weights include organ procurement costs for both solid and nonsolid organs (costs for acquiring/harvesting, processing, preserving, storing, distributing, and tissue typing). Nonsolid organs include bone marrow, peripheral stem cell, or cornea. The state agency or its designee makes no distinction between urban and rural hospitals and there is no federal/national portion within the payment.

(d) Add-on payments. There are no separate add-on payments. The state agency or its designee:

- (1) includes capital costs in the standard dollar amount for each payment division;
- (2) includes the costs of indirect medical education in the standard dollar amount for each payment division;
- (3) includes the cost of malpractice insurance in the standard dollar amount for each payment division; and
- (4) includes return on equity in the standard dollar amount for each payment division.

(e) Calculating the payment amount. The state agency or its designee reimburses each hospital for covered inpatient hospital services by multiplying the standard dollar amount established for the hospital's payment division by the appropriate relative weight. The patient's DRG classification is primarily based on the patient's principal diagnosis. The resulting amount is the payment amount to the hospital.

(f) Patient transfers. If a patient is transferred, the state agency or its designee establishes payment amounts as specified in paragraphs (1)-(4) of this subsection. If appropriate, the state agency or its designee manually reviews transfers for medical necessity and appropriate payment.

(1) If the patient is transferred to a nursing facility, the state agency or its designee pays the transferring hospital the total payment amount of the patient's DRG.

(2) If the patient is transferred to another hospital, the state agency or its designee pays the receiving hospital the total payment amount of the patient's DRG. The state agency or its designee pays the transferring hospital a DRG per diem. The DRG per diem is based on the following formula:

$$\frac{(\text{DRG relative weight} \times \text{standard dollar amount})}{\text{DRG mean length of stay (LOS)}} \times \text{LOS}$$

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The LOS is the lesser of the DRG mean LOS, the claim LOS, or 30 days. The 30-day factor is not used in establishing a DRG per diem amount for a medically necessary stay of a recipient less than age 21 in compliance with the EPSDT provisions of the Omnibus Budget Reconciliation Act of 1989 and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990.

(3) If the state agency or its designee determines that the transferring hospital provided a greater amount of care than the receiving hospital, the state agency or its designee reverses the payment amounts. The transferring hospital is paid the total payment amount of the patient's DRG and the receiving hospital is paid the DRG per diem.

(4) The state agency or its designee makes multiple transfer payments by applying the per diem formula to the transferring hospitals and the total DRG payment amount to the discharging hospital.

(g) Split billing. The state agency or its designee does not allow interim billings by providers. The hospital may bill the state agency or its designee when the patient exceeds his 30-day inpatient hospital limit or is discharged. The state agency or its designee bases payment on the diagnosis codes known at billing. The payment is final.

(h) Rebasing the standard dollar amounts. The state agency or its designee rebases the standard dollar amount for each payment division at least every three years. The relative weights are recalibrated whenever the standard dollar amounts are recalculated. The standard dollar amounts are not rebased on an interim basis unless the state agency or its designee determines that special circumstances warrant rebasing.

(i) Recalibrating the relative weights. The state agency or its designee recalibrates the relative weights whenever the standard dollar amounts are rebased or recalibrated.

(j) Revising the diagnosis related groups. The state agency or its designee parallels the taxonomy of diagnoses as defined in the Medicare DRG prospective payment system unless a revision is required based on Texas claims data or other factors as determined by the state agency or its designee.

(k) Appeals.

(1) A hospital may appeal individual claims as specified in other sections of this State Plan. As specified in subparagraphs (A), (B), and (C) of this paragraph, a hospital may also appeal mechanical, mathematical, and data entry errors in base year claims data and incorrectly computed subsequent adjustments to the hospital's base year claims data because of the base year's tentative or final settlement.

(A) If a hospital believes that the state agency or its designee made a mechanical, mathematical, or data entry error in computing the hospital's base year claims data, the hospital may request a review of the disputed calculation by the state agency or, at the state agency's direction, its designee. A hospital may not request a review if the disputed calculation is the result of the hospital's submittal of incorrect data or the result of the state agency's or its designee's application of an interim rate to the base year claims data derived from a cost reporting period occurring before the base year. Upon the provider hospital's request, the state agency or its designee provides the applicable available data used in calculating the hospital's base year claims data to the provider hospital. The hospital must submit a specific written request for review and appropriate specific documentation supporting

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its contention that there has been a mechanical, mathematical, or data entry error to the state agency or its designee. Except as specified in subparagraph (C) of this paragraph, the request must be submitted within 60 days after the hospital receives initial notification of its payment division and standard dollar amount. The state agency or its designee conducts the review as quickly as possible and notifies the hospital of the results. If the hospital is dissatisfied with the results of the review, the hospital may request a formal hearing under the contract appeals procedures, including the expedited processing provisions, established by the state agency, except that, in the event of any conflict, the procedures contained in this section apply. Except as specified in subparagraph (C) of this paragraph, if the review or appeal is completed at least 60 days before the beginning of the next prospective year, any adjustment required after the completion of the review or appeal is applied to that next prospective year. If the review or appeal is not completed at least 60 days before the beginning of the next prospective year, any adjustment required after the completion of the review or appeal is applied only to the subsequent prospective year. The base year claims data used by the state agency or its designee pending the review or appeal is the base year claims data established by the state agency or its designee.

(B) If a hospital believes that the state agency or its designee incorrectly computed subsequent adjustments to the hospital's base year claims data because of the base year's tentative or final settlement, the hospital may request a review of the disputed calculation related to the tentative or final settlement by the state agency or, at the state agency's direction, its designee.

The hospital's request may also include a request to review the tentative or final settlement. The hospital must submit a specific written request for review and appropriate specific documentation supporting its contention that the tentative or final settlement is incorrect to the state agency or its designee. Except as specified in subparagraph (C) of this paragraph, the request must be submitted within 60 days after the hospital receives notification of a tentative or final settlement of the base year data. The state agency or its designee conducts the review as quickly as possible and notifies the hospital of the results. If the hospital is dissatisfied with the results of the review, the hospital may request a formal hearing under the contract appeals procedures, including the expedited processing provisions, established by the state agency, except that, in the event of any conflict, the procedures contained in this section apply. Except as specified in subparagraph (C) of this paragraph, if the review or appeal is completed at least 60 days before the beginning of the next prospective year, any adjustment required after the completion of the review or appeal is applied to that next prospective year. If the review or appeal is not completed at least 60 days before the beginning of the next prospective year, any adjustment required after the completion of the review or appeal is applied only to the subsequent prospective year. The interim rate applied to the base year claims data pending the review or appeal is the interim rate established by the state agency or its designee.

(C) If a hospital believes that the state agency or its designee incorrectly computed the hospital's 1985 base year claims data as specified in subparagraph (A) of this paragraph, the hospital may submit a specific written request for review and appropriate specific documentation supporting its contention within 60 days after the effective date of this section. If a hospital believes that the state agency or its designee incorrectly computed the tentative or final settlement of the cost reporting period associated with the 1985 base year as specified in subparagraph (B) of this paragraph, the hospital may submit a specific written request for review and appropriate specific documentation supporting its contention within 60 days after the effective date of this

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section. The hospital must follow the process described in subparagraph (A) or (B) of this paragraph, as appropriate. If the review or appeal is completed by December 31, 1987, any adjustment required after the completion of the review or appeal is applied to the March 1, 1988, adjustment described in subsection (n) of this section. If the review or appeal is not completed by December 31, 1987, any adjustment required after the completion of the review or appeal is applied to the next prospective year.

(2) A hospital may not appeal the prospective payment methodology used by the state agency or its designee, including:

- (A) the payment division methodologies;
- (B) the DRGs established;
- (C) the methodology for classifying hospital discharges within the DRGs;
- (D) the relative weights assigned to the DRGs; and
- (E) the amount of payment as being inadequate to cover costs.

(l) Cost reports: Each hospital must submit a cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by the state agency or its designee. The state agency or its designee uses data from these reports in rebasing years, in making adjustments as described in subsection (n) and subsection (q) of this section, and in completing cost settlements for children's hospitals.

(m) Cost settlements. If a hospital has already begun its fiscal year on September 1, 1986, cost settlement for that portion of the hospital's fiscal year which occurs before September 1, 1986, is based on reimbursement for covered inpatient hospital services under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248. Except as otherwise specified in subsection (q) of this section, there will be no cost settlements for services provided to recipients admitted as inpatients to hospitals reimbursed under the prospective payment system on or after the implementation of the Texas DRG prospective payment system September 1, 1986.

(n) Adjustments to base year claims data.

(1) Beginning with 1985 hospital fiscal year cost reporting periods, the state agency or its designee adjusts each hospital's base year claims data and resulting payment division and standard dollar amount to reflect the interim rate established at tentative and final settlement, if applicable, of the cost reporting period associated with the base year. The adjustments are applied only to claims data for months within the base year that coincide with months within the hospital's cost reporting period. The claims data for months within the base year that do not coincide with months within the hospital's cost reporting period remain unchanged until the tentative or final settlement of the cost reporting period containing those months has been completed. The adjustments are applied to the next prospective year, beginning September 1, 1988, except as specified in subparagraphs (A), (B), and (C) of this paragraph.

(A) If the tentative or final settlement is not completed and available at least 60 days before the beginning of the next prospective year, any adjustment required because of the settlement is applied to the subsequent prospective year.

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(B) If a review or appeal of a tentative or final settlement is not completed at least 60 days before the beginning of the next prospective year, the interim rate applied to the claims data on which the hospital's payment division and standard dollar amount are established is the interim rate established at tentative or final settlement by the state agency or its designee. Any adjustment required after the completion of the review or appeal is applied only to the subsequent prospective year.

(C) The state agency or its designee makes a March 1, 1988, adjustment to each hospital's 1985 base year claims data and resulting payment division and standard dollar amount to reflect the interim rate established at tentative and final settlement, if applicable, of the cost reporting period associated with the 1985 base year. Any additional adjustments required as the result of reviews and appeals described in subsection (k) of this section and completed by December 31, 1987, are also reflected in the March 1, 1988, adjustment. Future adjustments as described in this subsection and subsection (k) of this section are made at the beginning of each prospective year.

(2) The state agency or its designee updates the standard dollar amount each year for each payment division by applying a cost-of-living index to the standard dollar amount established for the base year. The index used to update the standard dollar amounts is the greater of:

(A) the Health Care Financing Administration's (HCFA) Market Basket Forecast (PPS Hospital Input Price Index) based on the report issued for the federal fiscal year quarter ending in March of each year, adjusted for the state fiscal year by summing one-third of the annual forecasted rate of the index for the current calendar year and two-thirds of the annual forecasted rate of the index for the next calendar year; or

(B) an amount determined by selecting the lesser of the following two measures:

(i) the change in total charges per case for the latest year available compared to total charges per case for the previous year; or

(ii) the change in the Texas medical consumer price index-urban (that is, the arithmetic mean of the Houston and Dallas/Fort Worth medical consumer price indexes for urban consumers) for the latest year available compared to the Texas medical consumer price index-urban for the previous year.

(o) Reimbursement to in-state children's hospitals. The state agency or its designee reimburses in-state children's hospitals under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248, except for the cost of direct medical education. The state agency or its designee establishes target rates and stipulates payments per discharge, incentives, and percentage of payments. The state agency or its designee uses each hospital's 1987 final audited cost reporting period (fiscal year ending during calendar year 1987) as its target base period. The target base period for hospitals recognized by Medicare as children's hospitals after the implementation of this subsection is the hospital's first full 12-month cost reporting period occurring after its recognition by Medicare. The state agency or its designee annually increases each hospital's target amount for the target base period by the cost-of-living index described in subsection (n) of this section. The state agency or its designee selects a new target base period at least every three years. In compliance with the EPSDT requirements of the Omnibus Budget Reconciliation Act of 1989 to provide other necessary health care and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990, the costs of services provided to Medicaid-eligible individuals under age 21 are treated as pass-through costs and are calculated

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separately and distinctly from those costs subject to the TEFRA limit or target rate. The state agency or its designee bases interim payments to each hospital upon the interim rate derived from the hospital's most recent tentative or final Medicaid cost report settlement. If a Title XIX participating hospital is subsequently recognized by Medicare as a children's hospital after the implementation of this subsection, the hospital must submit written notification to the state agency or its designee and include adequate documentation and claims data. Upon receipt of the written notification from the hospital, the state agency or its designee reserves the right to take 90 days to convert the hospital's reimbursement to the reimbursement methodology described in this subsection.

(p) Day and cost outliers. In compliance with the EPSDT requirements of the Omnibus Budget Reconciliation Act of 1989 to provide other necessary health care and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990, the state agency or its designee pays day or cost outliers for medically necessary inpatient services provided to recipients less than age 21 in all participating hospitals that are reimbursed under the prospective payment system. If an admission qualifies for both a day and a cost outlier, only the outlier resulting in the highest payment to the hospital is paid.

(1) To establish day outliers, the state agency or its designee first removes from the current base year data those admissions whose actual lengths of stay are greater than or equal to plus or minus three standard deviations from the arithmetic mean length of stay for each DRG. The state agency or its designee then recomputes the arithmetic mean length of stay and the standard deviations for each DRG. Inpatient days which exceed two standard deviations beyond the arithmetic mean length of stay for the DRG are eligible for a day outlier. Payment is based on 70% of a per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG. For admissions occurring in the 1995-1995 biennium (September 1, 1993 - August 31, 1995), payment is based on 75% of the per diem amount of a full DRG payment.

(2) To establish cost outliers, the state agency or its designee first determines what the amount of reimbursement for the admission would have been if the state agency or its designee reimbursed the hospital under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248 (TEFRA). The state agency or its designee then determines the outlier threshold by using the greater of the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universe mean of the current base year data multiplied by 11.14 or the hospital's standard dollar amount multiplied by 11.14. The hospital's standard dollar amount is the amount that the state agency or its designee uses to reimburse the hospital under the prospective payment system. The outlier threshold is subtracted from the amount of reimbursement for the admission established under the TEFRA principles. The state agency or its designee multiplies any remainder by 70% to determine the actual amount of the cost outlier payment. For admissions occurring on or after September 1, 1993, the department or its designee multiplies any remainder by 75% to determine the actual amount of the cost outlier payment.

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